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Original Article

Perception of Community Leaders about Primary Health Care Services in a Selected Rural Area of Bangladesh

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ABSTRACT

Introduction: *Community leaders are directly or indirectly involved in the activities of primary health care services. They should be capable to involve and mobilize others, enable them by infusing a sense of purpose, commitment and focus of action etc. to participate in the implementation of primary health care services for the prevention and control of diseases and promotion of health of the people of that locality.* ***Objectives:*** *The aim of this study was to assess the level of perception of the community leaders about primary health care services.* ***Methods and Materials:*** *This was a descriptive type of cross-sectional study which was carried out in a selected rural area in Munshigonj district, Bangladesh among 105 community leaders (union porishad chairmans and members, teachers, imams and other social workers).Pretested questionnaire was used for data collection after taking informed written consent from the respondents, which included information regards to socio-demographic status, knowledge, attitude and participation of the community leaders towards the primary health care services.* ***Results:*** *Out of 105 respondents 92 (87.6%) were male, and 13(12.4%) were female. Of them 40% were HSC passed, followed by 19.1% SSC passed, 12% were Graduate and none of the community leaders found illiterate; 97 (92.3%) community leaders participated in the implementation of primary health care(PHC) program; 78.1% community leaders heard the term PHC. Knowledge about PHC and participation in various PHC programs were satisfactory among chairman, members, and teachers, but Imams and other social workers had average or poor knowledge and participation in primary health care (PHC) programs. 100% community leaders had correct knowledge about management of diarrhea by oral rehydration salts (ORS) use and 100% community leaders were using iodized salt, 85.7% community leaders were using sanitary latrine. 86.7% community leaders participated in family planning motivation activities and 76% community leaders expressed their need for training in various PHC programs.* ***Conclusion:*** *Community leaders should be informed*

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and trained about the various components of PHC, so that they can realize importance of their active involvement in implementation of every PHC programs for their respective localities for the improvement of the health and socio-economic development of the society as a whole.

Key words: *Primary Health Care (PHC), Immunization, Vaccine preventable diseases.*

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INTRODUCTION

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is therefore of common concern to all countries [1]. WHO defined Primary Health Care (PHC) as: "Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" [2]. The Alma-Ata Declaration of 1978 emerged as a major milestone in the field of public health and it identified primary healthcare (PHC) as the key to the attainment of the goal of "Health for All" around the globe [3]. "Health for all" means simply the realization of world health organization (WHO)'s objective of "the attainment by all people of the highest possible level of health" and that as a minimum all people in all countries should have at least such a level of health that they are capable of working productively and participating actively in the social life of the community in which they live. To attain such a level of health every individual should have access to primary health care (PHC) and through it to all levels of comprehensive health system [4].

PHC is the central function and main focus of a country's health system. One of the main principles of PHC is community participation [4]. The term community participation is commonly understood as the collective involvement of local people in assessing their needs and organizing strategies to meet those needs. Community participation is considered very important in primary health care development and there is some evidence to suggest that importance of community participation in rural health service development is uncontested [5,6].

Health is a basic requirement to improve the quality of life. A national economic and social development depends on the state of the health. The lack of participation in health service is a problem that has many dimensions and complexities. Education has a significant effect on participation in health services and administrative factors could play a significant role in increasing the people's participation in Bangladesh health sector [7]. Being a poor country with scarce resources, Bangladesh cannot afford to provide sophisticated medical care to the entire population. Emphasis therefore is given to PHC covering the unserved and underserved population with the minimum cost in the shortest time [8].

There are many ways in which community can participate in every stage of primary health care by adopting a healthy life style, by applying principles of good nutrition and

hygiene, or by making use of immunization services. In addition, members of the community can contribute labour as well as financial and other resources to primary health care [9]. Many countries have made encouraging efforts in training health workers including community leaders. At the same time it is also stressed that helping a community stay healthy is not a job that health workers can do alone. It requires help from community members and leaders as well [10].

Leader should be fully informed about PHC and the strategies for achievement and be able to communicate to others. They should be able to involve and mobilize others, enable them by infusing a sense of purpose, commitment and a focus of action [11]. The effectiveness and ability of community groups to function as space for participation and provide the means for developing capabilities to participate is limited, being constrained by poverty, social inequality and dependency relationships invisibility, low self-esteem and absence of political clout [12]. There have been increased problems encountered in the provision of health care services especially in developing countries of the world. Both government and community members have roles to play to reduce problems of primary health care service [13].

In primary health care development, community participation in the rural Bangladesh, should involve chairman and members, headmasters of Govt. primary school, Imams of mosques, as community leaders, and other social workers along with Government and Non-Government health workers. So community leaders having appropriate and sufficient knowledge about PHC is very essential for the success of development of rural community health. This study aimed to assess the level of perception of the community leaders about primary health care services.

METHODS AND MATERIALS

This descriptive type of cross- sectional study was conducted in selected rural area of Bangladesh for a period of 04 months starting from September, 2017 to December, 2017 to assess the level of perception of community leaders about primary health care services. The study was conducted in Sreenagar upazila of Munshigonj District. The study population consists of elected Chairmans & Members of the Union Parishad, Head Masters of Government primary school, and Imams and other Social workers of that Upazila. Using convenient type of Non-probability sampling technique, 105 community leaders were purposely and randomly selected for interview and accordingly their interview was taken. Primarily contact was made with the community leaders & consult with them about the study program & hence set up schedule for interview. A Semi-structured pretested questionnaire was administered for data collection, which include socio-demographic profile of the respondents, knowledge, practice and opinion of respondents about primary health care services in that area. Informed written consent was taken from each respondent. Face to face interview was taken.

Only the fully completed questionnaire was entered into the computer for final analysis. Data entry and analysis were done by using SPSS-version-17.Descriptive statistics like mean and percentage were used. Available data were edited and compiled in a master sheet, then processed manually according to the objectives of the study. Essential calculation was done with scientific calculator. Tables were computed and statistical calculations were done accordingly. Frequency distribution and computation of descriptive measures such as

percentage, mean & standard deviation were done where necessary.

RESULT

Out of 105 respondents, chairmen were 12, members were 48, teachers were 25, Imams were 10, and other social workers were 10. Among them 92(87.6%) community leaders were male and only 13(12.4%) were female (Table I)

Table I: Distribution of respondents by sex

Sex	Chairman No (%)	Member No (%)	Teacher No (%)	Imam No (%)	Social workers	Total No (%)
Male	12 (100%)	42 (87.5%)	20 (80%)	10 (100%)	8 (80%)	92 (87.6%)
Female	0	6 (12.5%)	5 (20%)	0	2 (20%)	13 (12.4%)
Total	12 (100%)	48 (100%)	25 (100%)	10 (100%)	10 (100%)	105 (100%)

Table II: Distribution of respondents according to education level

Educational level	Chairman No (%)	Member No (%)	Teacher No (%)	Imam No (%)	Social Workers No (%)	Total No (%)
Illiterate	nil	Nil	Nil	nil	nil	Nil
Sign only	1 (8.3%)	4 (8.3%)				5 (4.7%)
Class I-V	1 (8.3%)	4 (8.3%)				5 (4.7%)
Class VI-X	4 (33.3%)	16 (33.3%)				20 (19.1%)
SSC		14 (29.1%)		6 (60%)		20 (19.1%)
HSC	2 (16.7%)	8 (16.7%)	20 (80%)	4 (40%)	8 (80%)	42 (40%)
Graduate	4 (33.3%)	2 (4.2%)	5 (20%)		2 (20%)	13 (12.4%)
Total	12(100%)	48 (100%)	25 (100%)	10 (100%)	10 (100%)	105 (100%)

Table III: Distribution of respondents according to whether they heard the term PHC or not.

Heard about PHC	Chairman No (%)	Member No (%)	Teacher No (%)	Imam No (%)	Social workers No (%)	Total No (%)
Yes	9 (75%)	38 (79.1%)	22(88%)	7(70%)	6 (60%)	82 (78.1%)
No	3 (25%)	10 (20.8%)	3 (12%)	3 (30%)	4(40%)	23 (21.9%)
Total	12 (100%)	48 (100%)	25(100%)	10 (100%)	10 (100%)	105(100%)

Table II showed that none of the community leaders found illiterate, only 5(4.7%) can sign, 5(4.7%) read up to V, 20(19.1%) read up to class X, 20(19.1%) were SSC passed, 42(40%) were HSC passed and 13(12.4%) were Graduate.

Table III showed that majority of the community leaders 82(78.1%) heard the term PHC and 23(21.9%)did not hear the term PHC.

Table IV showed that 76.2 % (80) community leaders know the exact number of vaccine preventable diseases.

Table V showed that 87(82.8%) community leaders know the exact beginning age of child immunization

Table IV: Distribution by knowledge about the no. of vaccine preventable diseases of the children.

Preventable diseases	Chairman	Member	Teacher	Imam	Social worker	Total
8	2 (16.1%)	5 (10.4%)	2 (8%)	2 (20%)	3 (30%)	14(13.3%)
9	-	3 (6.3%)	-	-	-	03(2.9%)
10	10 (83.3%)	36 (75%)	23 (92%)	6 (60%)	5 (50%)	80 (76.2%)
Not known	-	4 (8.3%)	-	2 (20%)	2 (20%)	08(7.6%)
Total	12 (100%)	48 (100%)	25 (100%)	10 (100%)	10(100%)	105(100%)

Table V: Distribution of the respondents by knowledge about beginning age of immunization.

Age of Children	Chairman	Member	Teacher	Imam	Social workers	Total
1&1/2 month	10(83.3%)	40(83.3%)	24(96%)	8(80%)	5(50%)	87(82.8%)
2 months	2(16.1%)	08(16.7%)	1(4%)	2(20%)	5(50%)	18(17.2%)
Total	12(100%)	48(100%)	25(100%)	10(100%)	10(100%)	105(100%)

Table VI: Distribution by knowledge about the necessity of vaccination of pregnant mother.

Vaccination in pregnancy	Chairman	Member	Teacher	Imam	Other social worker	Total
Yes	12(100%)	48(100%)	25(100%)	5(50%)	5 (50%)	95 (90.5%)
No	-	-	-	5(50%)	5 (50%)	10 (9.5%)
Total	12(100%)	48(100%)	25(100%)	10(100%)	10 (100%)	105 (100%)

Table VII: Distribution of respondents according to whether received training about PHC or not

Received training	Chairman No (%)	Member No (%)	Teacher No (%)	Imam No (%)	Social worker No (%)	Total No (%)
Yes	2 (16.7%)	4 (8.3%)	8 (32%)	2 (20%)	2 (20%)	18 (17.1)
No	10 (83.3%)	44 (91.7%)	17 (68%)	8 (80%)	8 (80%)	87 (82.9)
Total	12 (100%)	48 (100%)	25 (100%)	10 (100%)	10 (100%)	105(100%)

Table VI showed that 90.5 % (95) community leaders has knowledge about necessity of vaccination of pregnant mother.

Table-VII showed that 87(83%) of the community leaders did not receive any training in PHC program.

Table-VIII showed that majority of the community leaders 85.7% (90) participated in installation of sanitary latrine.

Table VIII: Distribution of respondents according to participation in sanitary latrine installation in the Community.

Sanitary latrine installation	Chairman No (%)	Member No (%)	Teacher No (%)	Imam No (%)	Other social worker No (%)	Total No (%)
Yes	12 (100%)	43 (89.5%)	22 (88%)	7 (70%)	6 (60%)	90 (85.7%)
No		5 (10.5%)	3 (12%)	3 (30%)	4 (40%)	15 (14.3%)
Total	12 (100%)	48 (100%)	25 (100%)	10 (100%)	10 (100%)	105 (100%)

DISCUSSION

Among 12 Chairman, 4(33.3%) were graduate and grand total of 13(12.4%), out of 105 community leaders, were graduate which indicate that responsibility of the community development as a whole are taken now a days by the highly educated personnel. Community leaders are the persons who are followed by the community people, so they practice first and set examples for community people. If they do not practice, people will not participate in PHC activities, which may hamper in the implementation of PHC programs.

In this study, majority of the community leaders had satisfactory knowledge about various PHC programs, viz. basic sanitation, safe drinking water supply, which indicates that they were very much aware about the importance of various components of primary health care. In developing country like Bangladesh, the role of community leaders is of great importance.

In a study it was revealed that 71% population expressed their ignorance about the PHC programs [8] On the

contrary in our study it was revealed that 78.1% community leaders heard the term PHC before starting this study in that area. Another study revealed that 77.2% of village health volunteers (VHVs) gave opinion for further refresher's training of VHVs, 52.2% in favor of provision of little incentives for the VHVs and 3.9% in favor of future job for VHVs in health service.[14] Other study showed that the concept of community participation was not clear to 89% of community leaders in the study area [15]. On the other hand in our study we found that 92.3% Community leaders participated in implementation of PHC program.

Another study found that 52.9% of the volunteers expressed opinion in favour of refresher training [16]. But in our study we found that 76.2% respondents passed opinion for conduction of fresher training of the community leaders.

In a study, it was revealed that direct participation of community leaders varied in degrees, which was satisfactory in Vaccination and Safe water supply (94.4%) but not satisfactory in basic sanitation and family planning practices (60.2%) [17]. Whereas in our study, we found 85.7% community leaders participated in sanitary latrine installation i.e. more community leaders participated in basic sanitation than that study.

Health service based on PHC has been expanding gradually in Bangladesh to improve the health status of the people especially in rural areas where 85% of the population are living. This study revealed that perception of community leaders about various components of PHC was satisfactory but not up to the mark for all. All community leaders should be informed and trained periodically, so that they can realize the importance of their active involvement in the implementation of every PHC programs for their respective localities for the improvement of health and socio-economic development of the society as a whole.

CONCLUSION

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